**Low Risk ____**
**1 or more "No's" checked = High Risk ____**

# MONITORING REPORT
# ADULT DAY CARE AND ADULT DAY HEALTH

DATE OF VISIT: _____

I. PROGRAM: _____ COUNTY: _____

II. TYPE OF VISIT: ( ) Announced ( ) Unannounced TIME OF VISIT: _____

III. ENROLLMENT: # Full-time ___ # Part-Time ___ Month Reviewed _____
ATTENDANCE: # Participants at time of visit _____ # of Staff _____

IV. CONCERNS FROM PREVIOUS VISIT: _____
_____
_____
_____
_____

Have these concerns been resolved? ( ) YES ( ) NO (If no, complete DSS Form 6215)

V. AREA REVIEWED:

**Medications** [10A NCAC 06R .0505 and 06S .0401] – Standards, Pages 26-27

| Yes | No | N/A | |
|---|---|---|---|
| ( ) | ( ) | ( ) | Medications are administered according to the participant's established medication schedule as determined on the participant's medical examination report or as authorized by the responsible caregiver. |
| ( ) | ( ) | ( ) | Participants who are able to may keep and administer their own medications. |
| ( ) | ( ) | ( ) | A record of medications given to each participant is kept indicating each dose given and includes the following:<br>❑ participants name;<br>❑ name, strength, and quantity of the medication;<br>❑ instructions for giving the medication;<br>❑ date and time medication is administered; and<br>❑ name or initials of person giving the medication. If initials are used, a signature equivalent to those initials is entered on this record. |
| ( ) | ( ) | ( ) | Medications kept by the program are in the containers in which they were dispensed |
| ( ) | ( ) | ( ) | Containers are clearly labeled with the participant's full name, the name and strength of the medication, dosage, and instructions for giving the medication. |
| ( ) | ( ) | ( ) | Medications kept by the program are locked in a safe place. |

*Continued on Back*

Make copies for DSS file; Program Director, and State Adult Day Services Consultant.

 Check Yes, No, or N/A* (not applicable). If no, provide explanation.

*Note, N/A would be used for programs who do not administer medications and/or those that do not have any participants taking medications while at the program If not administering meds, there should be apolicy to this effect

**MONITORING REPORT**
**ADULT DAY CARE AND ADULT DAY HEALTH**

**Medications (Continued)**

VI. COMMENTS/CONCERNS _____
_____
_____
_____
_____
_____
_____

*Attach an additional sheet if needed*

VII. PROGRAM DIRECTOR'S COMMENTS _____
_____
_____
_____
_____
_____

VIII. Continued by ( ) DSS-6215 ( ____ # of forms)

IX. Signatures:

_____ _____ _____ _____
Coordinator and/or Specialist Date Program Director Date

Make copies for DSS file; Program Director, and State Adult Day Services Consultant.

 Check Yes, No, or N/A* (not applicable). If no, provide explanation.
*Note, N/A would be used for programs who do not administer medications and/or those that do not have any participants taking medications while at the program If not administering meds, there should be apolicy to this effect